DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 04-02

2. STATE: Alaska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1927 of the Act; 42 CFR 440

7. FEDERAL BUDGET IMPACT:
a. FFY 04 $ (69,000)
b. FFY 05 $ (138,000)
Please see Box 10, below

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Pages 5, 5a and 6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A , Pages 4

10. SUBJECT OF AMENDMENT
Outpatient Payment Rate Update

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Governor does not wish to comment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Bob Labbe Bob Labbe

14. TITLE:
Deputy Commissioner/Medicaid Director

15. DATE SUBMITTED:
March 31, 2004

16. RETURN TO:
Alaska Department of Health and Social Services
Office of the Commissioner
P.O. Box 110601
Juneau, Alaska 99811-0601

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: APR - 2 2004

18. DATE APPROVED: NOV - 3 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN - 1 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Karen S. O'Connor

22. TITLE:
Associate Regional Administrator -
Division of Medicaid + Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

Methods and Standards for Establishing Payment Rates: Other Types of Care

Nutrition Services

Payment to a registered dietitian is limited to the lesser of the amount billed the general public or a maximum of $50 for an initial assessment, counseling, or evaluation; and $35 for each subsequent visit.

Outpatient Hospital Services

Rate setting principles and methods for Outpatient Hospital Services are contained in Alaska Statutes 47.07.070 - 47.07.900 and administrative regulations in Alaska Administrative Code 7 AAC 43. The Department of Health and Social Services uses the following data sources for setting rates of payment:

- When rebasing occurs, the Medicare Cost Report for the facility's fiscal year ending 12 months before the beginning of the year that is rebased (base year).
- Budgeted capital costs, submitted by the facility and reviewed and adjusted by the Department as appropriate for the rate year on capital projects or acquisitions which are placed in service after the base year and before the end of the rate year and for which an approved Certificate of Need has been obtained.
- Year-end reports that contain historical financial and statistical information submitted by facilities for past rate setting years.
- Utilization and payment history report (commonly known as the MR-0-14) provided by the Division of Medical Assistance.

Allowable costs are documented costs that are ordinary and necessary in the delivery of a cost effective service. Allowable costs are those that directly relate to Title XIX program recipients. Costs would include those necessary to conform to state and federal laws, regulations, and quality and safety standards.

Most of the elements of Medicaid allowable costs are defined in Medicare and reported, subject to audit, on the Medicare Cost Report. The following items are possible allowable and unallowable cost adjustments from financial statement classifications to Medicaid classifications that may be reflected either within the Medicare Cost Report or elsewhere in the Medicaid cost finding process.

1) physician compensation costs and related charges associated with providing care to patients are not allowable for purposes of calculating a prospective payment rate.

2) medical services which a facility or unit of a facility is not licensed to provide are not included as an allowable cost.

3) costs not authorized by a certificate of need when a certificate of need is required are not included as an allowable cost.

4) management fees or home office costs which are not reasonably attributable to the management of the facility are not allowable. Home office costs may not exceed those reported in the most recently Medicare audited Home Office Cost Report.

5) return on investment is not an allowable cost for any facility.

6) advertising cost is allowable only to the extent that the advertising is directly related to patient care. The reasonable cost of the following types of advertising and marketing is allowable:
   - announcing the opening of or change of name of a facility.
   - recruiting for personnel.
   - advertising for the procurement or sale of items.
   - obtaining bids for construction or renovation.
   - advertising for a bond issue.
   - informational listing of the provider in a telephone directory.
   - listing a facility's hours of operation.
   - advertising specifically required as a part of a facility's accreditation process.

Allowable patient related costs include wages, salaries, and employee benefits, purchased services; supplies; utilities, depreciation, rentals, leases; taxes, excluding local, state and federal income taxes; and interest expense. A facility must reduce operating costs by the cost of all activities not directly related to health care. Other specific non-allowed costs are bad debts, charity, contractual adjustments and discounts taken by payers. Certificate of need capital is not included in the percentage of charges rate for outpatient hospital services.

Prospective payment rates for outpatient hospital services are a percentage of charges except outpatient clinical laboratory services and provider based clinic services. Except as stated in this Subsection, the prospective payment rate for outpatient clinical laboratory services will be a per-procedure rate based on reasonable costs as determined by the Medicare fee schedule.

The prospective percentage of charges payment rate for acute hospital outpatient services is determined by applying the outpatient cost to charge ratio for each outpatient cost center from the Medicare Cost Report to the cost center's Medicaid outpatient charges. Laboratory and clinic cost centers are not included in the calculation. The sum of the Medicaid outpatient costs for all outpatient cost centers will then be divided by total Medicaid outpatient charges. The resulting cost to charge percentage, not to exceed 100 percent, will be the prospective outpatient payment rate effective for the fiscal year. Facilities choosing reimbursement under the Optional Prospective Payment Rate Methodology for Small Facilities described in Attachment 4.19A will have their outpatient clinical laboratory services reimbursed at their prospective outpatient percentage of charges payment rate for the term of their agreement.

Rebasing will occur for all facilities no less than every four years.

Facilities may choose to be reimbursed under an Optional Prospective Payment Rate Methodology for Small Facilities. A small acute care hospital facility is defined as one that had 4,000 or fewer total inpatient hospital days as an acute care, specialty, or psychiatric hospital or at a combined hospital-nursing facility during the facility's fiscal year that ended 12 months before the beginning of its prospective payment rate year.

A small acute care hospital may elect a new four-year rate agreement if the facility becomes a combined acute care hospital-nursing facility and meets the qualifications described in this section. The facility may choose this option within 30 days after the two facilities combine. The outpatient percentage rate is calculated as the statewide average of the outpatient payment rates in effect for all qualified acute care hospital small facilities as of the date the facilities combine.

For a new facility, the outpatient prospective payment rate percentage is established at the statewide weighted average outpatient payment percentages of acute care and specialty hospitals, in accordance with this section for the most recent 12 months of permanent rates. To determine this weighted average Medicaid charges for the most recent 12 months from each facility are multiplied by the facility's respective rate to get the payment. The sum of facilities' payments is then divided by the sum of their charges to calculate a weighted average outpatient payment percentage.

Methods and Standards for Establishing Payment Rates: Other Types of Care

Physician Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale (RBRVS) methodology, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established Relative Value Unit (RVU). The Resource Based Relative Value Scale methodology is that described in 42 CFR 414 except that increases and reductions to the average payment made for an individual procedure code billed at least ten times during the previous fiscal year will be phased in until the year 2000. The relative value units used are the most current version published in the Federal Register. Non-routine office supplies are reimbursed at the lesser of billed charges or the state maximum allowable.

Payment for the services of a physician collaborator is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Physician collaborators are a physician assistant, advanced nurse practitioner, physical therapist, occupational therapist, audiologist, speech language pathologist, certified registered nurse anesthetist, or a community health aide III or IV or a community health practitioner certified by the state.

Surgical reimbursement is in accordance with the Resource Based Relative Value Scale methodology except that multiple surgeries performed on the same day are reimbursed at 100 percent of the RBRVS rate for the highest procedure and 50 percent of the RBRVS rate for each additional surgery; bilateral surgeries are reimbursed at 150 percent of the RBRVS rate; co-surgeons are reimbursed by increasing the RBRVS rate by 25 percent and splitting payment between the surgeons; and supplies associated with surgical procedures performed in a physician's office are reimbursed at the lesser of billed charges or the state maximum allowable. Payment is made to surgical assistants at the lesser of billed charges or 25 percent of the Resource Based Relative Value Scale methodology.

Laboratory services are reimbursed at the lesser of the amount billed the general public or the Medicare fee schedule. Prescription drugs dispensed by a physician are reimbursed at 95% of the Average Wholesale Price (AWP) without a dispensing fee.

Payment is made to independently enrolled hospital-based physician for certain services at the lessor of the amount billed the general public or 100 percent of the Resource Based Relative Value Scale methodology.

Anesthesia services are reimbursed using base units and time units and a state determined conversion factor.